X Clinical Commissioning Group (XCCG)

Accountability Agreement

2012-13

Accountability Agreement between X Clinical Commissioning Group (XCCG) and

…… (Name of Practice)

1. Parties to the Agreement;

This Agreement is made between the Practice and X Clinical Commissioning Group (which is a shadow Clinical Commissioning Group pending authorisation)

1.1 The practice is to form part of the X Clinical Commissioning Group identified in this Agreement.

The authorised officer empowered to act on behalf of the Practice is the nominated Practice Lead identified later in the document.

2. Aims

2.1 This agreement sets out the relationship between X Clinical Commissioning Group (XCCG) and the practice during the transition period and beyond. It should be read in conjunction with the XCCG Constitution

2.2 The purpose of XCCG Group is to bring together practices to commission health care services for the benefit of patients registered within the X area. All practices are required to meet the practice level responsibilities as outlined in this agreement.

2.3 The purpose of XCCG derives from the NHS Constitution, and supports a service which:

2.3.1 Is comprehensive and based on clinical need rather than an individual's ability to pay

2.3.2 Aspires to the highest standards of excellence and professionalism

2.3.3 Reflects the needs and preferences of patients and their families and carers

2.3.4 Provides best value for taxpayers' money and the most effective, fair and sustainable use of finite resources

2.3.5 Is accountable to the public, communities and patients that it serves

2.3 The CCG will not be accountable for the direct commissioning of primary care as this will be undertaken by the National Commissioning Board

3. Strategic objectives of X Clinical Commissioning Group (XCCG)

To work in partnership with our patients and our partners, including Local Authorities, voluntary sector and providers of NHS health services to:

3.1 Secure highest quality, safe health services based on clinical need that offer patients, carers and relatives a positive experience

3.2 Avoid the need for hospital-based care wherever appropriate and possible and establish services that work more effectively and directly with partners across the system to avoid unnecessary hospital admissions and bring care closer to home

3.3 Demonstrably improve health outcomes in areas of particular need and deprivation by use of improved and innovative partnership working.

3.4 Uphold the rights of the NHS constitution

3.5 Stay within delegated budgets and support X PCT during the transition year in fulfilling its statutory responsibilities to achieve financial balance by:

3.5.1 Ensuring best use of public resources

3.5.2 Improving the value for money, efficiency and productivity of our expenditure decisions

3.5.3 Developing a robust medium term financial plan.

3.6 Campaign for the allocation of national resources for X based on its fair share

4. Structure of Clinical Commissioning in X

4.1 The governance structure of XCCG, including GP members elected by the member practices is set out in Annex A

5. Role and Responsibilities of the PCT

5.1 The role of the PCT during the shadow period will be to provide support to practices, locality groups and X Clinical Commissioning Board to enable them to comply with their shadow status prior to authorisation via a scheme of delegation as summarised in Annex B

6. Role and Responsibilities of the X Clinical Commissioning Group

6.1 XCCG comprises of groups of practices, comprising of three localities which have chosen to work together in commissioning services on behalf of their population.

6.2 All practices in XCCG must belong to a locality group. Whilst locality groups analyse commissioning activity and spend, they are not formally a budget holding group.

6.3 XCCG roles and responsibilities include;

6.3.1 Representing localities and their member practices

6.3.2 Setting and communicating the vision and strategic direction of the XCCG and supporting the development and implementation of Clinical Commissioning transitional plans

6.3.3 Monitoring the commissioning activities supported by the Commissioning Support Unit to ensure the services commissioned meet the health needs of the population, deliver agreed outcome measures and are delivered within the budget allocations delegated by X PCT

6.3.4 With the support of the Commissioning Support Unit/PCT, providing the clinical leadership for the delivery of QIPP programmes and be collectively responsible for the implementation, monitoring and delivery of QIPP programmes

6.3.5 Providing the clinical leadership and support for the monitoring and performance management of contracts for commissioned services

6.3.6 Monitoring the implementation and delivery of health systems productivity and efficiency initiatives (QIPP)

6.3.7 Work with and ensure appropriate support to CCG member practices to fulfil their terms of the agreed Accountability Agreement

6.3.8 Support the formulation and implement clinical and operational policy as agreed by the XCCG Board

6.3.9 Champion health inequalities, health promotion and public involvement

6.3.10 Ensuring multi-professional engagement and involvement in commissioning decisions, including Local Authority, Voluntary Sector, secondary, community and private providers

6.3.11 Ensuring leadership for the health economy wide work on service redesign

6.3.12 Identifying the organisational development needs of the CCG and member practices and ensuring the organisation is prepared for authorisation during

2012

6.3.13 Delivering agreed outcomes and deliver within the budget allocations as delegated by the PCT Board

6.3.14 Responsible for actively promoting the involvement of the wider GP community in Locality activities and its development

6.3.15 Agree the strategic direction of the CCG informed by its localities including the most appropriate organisational form for member practices and their patients

6.3.16 Agree the CCG business plan

6.4 The CCG will further support engagement as advocated through the LMC Guidance, July

2011 as follows;

Frequency of meetings

All practices should receive one visit per year from the commissioning group to discuss practice level issues. In addition the CCG will assume the responsibility for the AGM as from 2013 from which time there should be at least two other commissioning group wide meetings for all practice members that do not have the public in attendance.

Annual General Meeting (AGM)

The commissioning group will hold an AGM that will be open to all constituent GPs and members of the public.

Survey of Practices

The commissioning group will undertake an annual survey of practices to obtain feedback on levels of satisfaction and perceived engagement with the commissioning process. The LMCs and EQUIP will jointly produce a Questionnaire for use by commissioning groups. The results will be analysed by the LMCs and EQUIP and feedback provided to commissioning groups.

7. Role and Responsibilities of Member Practices

7.1 To identify a nominated lead GP from within the practice who will act as the primary point of contact to represent practice views at locality and other meetings and promote the work of the XCCG

7.2 The responsibilities of member practices to the CCG, (based on LMC constitution section

17.5) will include:-

. Nominating commissioning and prescribing leads to a) represent the practice at CCG/locality meetings and b) represent the needs of the practice's patient population within the CCG.

. Actively engaging with the CCG to help improve services within the area.

. Sharing appropriate referral, prescribing and emergency admissions data.

. Agree the annual budget including prescribing

. Receive financial and activity monitoring information, responding on behalf of the practice to the CCG for requests for information and action in relation to this

. Ensure that the practice can demonstrate optimal use of the NHS resource and support the CCG in line with its delegated budget

. Following the clinical pathways and referral protocols agreed by the CCG (except in individual cases where there are justified clinical reasons for not doing this).

. Participating in and delivering, as far as possible, the clinical and cost effective strategies agreed by the CCG.

. Actively support the CCG in obtaining the views and experiences of patients and carers.

. Working constructively with the locality sub-committee/CCG.

. Responding in a timely manner to information requests from the CCG.

7.3 Performance

7.3.1 As recommended by the LMC, the CCG approach to practice engagement and accountability will take account of the following principles:-

a) All GPs and practices will have an obligation to participate in the process.

b) The NHSCB holds the contracts for all managed practices. It is their role to performance manage the practices' compliance with GMS/PMS contracts.

c) Commissioning groups will not have any powers to expel individual practices from the organisation as part of their local performance management arrangements.

d) Each commissioning group will be required to consult with the LMC annually on its intended performance management regime in so far as it relates to any quality payments

e) The performance of practices will be monitored by means of regular meetings and data returns, probably quarterly and probably based at a locality level.

f) Regular sharing of information will allow issues to be identified at an early stage and remedial action taken as and when necessary throughout the year.

g) Any disagreement over issues arising as part this agreement will be dealt with in accordance with the CCG's Dispute Resolution Procedure (consistent with the CCG constitution).

h) The commissioning group's performance management processes will not detract in any way from the responsibilities of individual GPs to report any concerns about the conduct of colleagues as outlined in the GMC's "Good Medical Practice".

8 Annual Objectives targets agreed with the CCG

8.1 XCCG in discussion with practices may agree targets as an addendum to this agreement going forward

9 Indicative budgets

9.1 Indicative practice budgets will be circulated for agreement once the main PCT contracts/SLAs have been finalised. In this shadow year, financial information will be evolving as contract/SLA costs are disaggregated between CCG, NCB and Public Health budgets.

9.2 Budgets and data sources at practice level are at an early stage of development and therefore many budgets and costs will initially be apportioned on an appropriate basis whilst reporting is developed.

10 Funding arrangements i.e. Incentive schemes

10.1 XCCG in discussion with practices may choose to develop incentive schemes to assist in the achievement of targets. These will be based on outcome.

11. Financial resources made available to support member practice involvement

11.1 Work approved in advance by XCCG board on behalf of either the CCG or the Locality will remunerated at an agreed sessional rate

11.2 The number of sessions will be agreed on an individual basis by the CCG Chair and Remuneration Committee as appropriate depending on the delegated responsibilities.

11.3 These sessional allocations will be reviewed on a six monthly basis by the GP Commissioning Board to ensure it is a fair reimbursement from the resources available for the time spent supporting GP Commissioning.

11.4 The CCG will review the resources available for supporting practice involvement on an annual basis

12. Meetings

12.1 Locality Meeting as suggested by the majority of CCG practices will meet no less than quarterly.

12.2 Each locality will nominate its own chair, and agree its own terms of reference based on a CCG template, to include attendance, meeting location and conflict of interests

12.3 Locality meetings will be minuted by a locality member and are to be shared with the member practices and CCG

12.4 Each locality will be assigned an Elected GP board member and Service Delivery

Manager to both attend locality meetings and to act as a day to day conduit with

XCCG

13. Dispute Resolution

13.1 In the event of any dispute there will be a simple, fair, transparent and minimally bureaucratic process consistent with the LMC dispute resolution process as set out in

Annex C

14. Termination of membership

15.1 Should a member practice no longer hold a contract to provide primary care services to its registered population, then its membership of the Locality and XCCG is automatically terminated.

15. Review of the Agreement

16.1 This Accountability Agreement will be reviewed in December 2012 and thereafter on an annual basis with a view to coming into effect as from April 1st each year, or sooner in the light of new policy or guidance.

16.2 This Accountability Agreement should be read in conjunction with the following documents:

o Department of Health, Equity and Excellence: Liberating the NHS, July 2010

o The local PCT

o Department of Health, Revision to the Operating Framework for the NHS in England

2010-11, June 2010

X Clinical Commissioning Group Accountability Agreement

1st April 2012 to 31st March 2013.

SIGNATURE SHEET

We agree to abide by the terms set out in the Accountability Agreement between X Clinical Commissioning Group and

…….. Practice

And confirm that the nominated practice lead is……..

Signed …….. on behalf of the Practice